November 26, 2002

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne Brathwaite Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

REPORT ON THE IN-HOME SUPPORTIVE SERVICES (IHSS) WORKER HEALTH CARE PLAN

On October 1, 2002, on a motion by Supervisor Yaroslavsky, your Board instructed my office to report back on the cost-effectiveness of reducing the eligibility threshold from 112 hours to 80 hours per month for In-Home Supportive Services (IHSS) workers in the Personal Assistance Services Council-Service Employees International Union (PASC-SEIU) Homecare Workers Health Care Plan (Health Care Plan).

While the initial service cost and utilization data from the Department of Health Services (DHS) indicates that the Health Care Plan could remain financially viable with a change in the eligibility threshold to 80 hours per month, DHS staff and my office have concerns regarding the reliability of the available data, as discussed in the attached report. Therefore, the report on the cost-effectiveness of this change should be deferred until February 2003, to allow DHS staff and my office to validate the service cost and utilization data before we conclude our analysis of this issue.

Deferring any action on a change in eligibility until February is also advised, because the PASC, the employer of record for IHSS workers in Los Angeles County, has established the IHSS Operational Steering Committee, and has requested its enrollment administrator to calculate the potential increase in enrollees based on an 80-hour threshold for eligibility. This Steering Committee is expected to have the results of their review completed by January 2003. We believe that a change in the Health Care Plan should be considered after the PASC has received the Steering Committee information, particularly since it may affect PASC-SEIU discussions on IHSS worker benefits.

Finally, your Board is currently scheduled to consider DHS System Redesign recommendations on January 21, 2002, which may affect the expansion of eligibility for the IHSS worker Health Care Plan. Our follow-up report in February 2003 will include a review of actions your Board may take at that time.

If you have questions or need additional information, please call me or have your staff contact Greg Polk or Amy Bennett of my staff at (213) 974-1791 or (213) 893-9742 respectively.

DEJ:DL
AB:bjs

Attachment

c: Executive Officer, Board of Supervisors
Director of Health Services
Director of Public Social Services

PERSONAL ASSISTANCE SERVICES COUNCIL-SERVICE EMPLOYEES INTERNATIONAL UNION (PASC-SEIU) HOMECARE WORKERS HEALTH CARE PLAN - PRELIMINARY ANALYSIS

Chief Administrative Office (CAO) staff worked with the Departments of Health Services (DHS) and Public and Social Services (DPSS) in analyzing the first six months of data on the Personal Assistance Services Council-Service Employees International Union (PASC-SEIU) Homecare Workers Health Care Plan (Health Care Plan). While preliminary data from DHS' information systems suggests that it may be financially viable to change the Health Care Plan eligibility from the current 112 hours or more per month to 80 hours or more per month, there are concerns regarding the reliability of this data, as discussed below. Therefore, the report on the cost-effectiveness of this change should be deferred until DHS and CAO staff can validate the service cost and utilization data in order to conclude their analysis of this issue.

Background

On March 27, 2001, the Board of Supervisors instructed DHS to develop a health benefits package for IHSS workers by expanding the CHP. This action was taken after a financial analysis determined that the Health Care Plan could be implemented within the Department's current resources. The Health Care Plan became operational in January 2002, with benefits beginning in April 2002.

The earlier financial analysis of the health needs of the IHSS workforce indicated that program costs would be high. The profile of IHSS workers reflected an older population, in generally poorer health than other low-income groups, such as the family-based population served by Medi-Cal managed care plans. Rising costs for prescription drugs and other medical services were projected to increase the cost of caring for this population.

While the Health Care Plan was designed to cover these health care costs, it was recognized that there was a lack of experience with the IHSS worker population, and that it was important to monitor actual experience of this Health Care Plan compared to the actuarial study in order to determine long-term financial viability.

Demographics

Consistent with earlier analysis provided by CAO and DHS, this Health Care Plan appears to serve an older patient population. Approximately 81 percent of the eligible IHSS providers are female, 26 percent are between the ages of 36 and 45 years, and 37 percent are between the ages of 46 and 55 years.[1]

The IHSS population contrasts with the Medi-Cal Managed Care and Healthy Families populations in that the Medi-Cal Managed Care Program serves primarily young families with children, and the Healthy Families Program provides care to eligible children under the age of 19.

Information Systems

Consistent with the earlier analysis provided to the Board on March 27, 2001, the CHP's managed care information system was inadequate to accommodate the IHSS product line, and the Board therefore approved outsourcing this activity to L.A. Care on June 26, 2002.

After further review and analysis, it was found that the information systems used to report utilization data for the facilities for this program were inadequate as well.

Chief Administrative Office staff will continue to work with DHS to identify the specific problem areas related to the information systems, and to refine/automate the process where appropriate for the collection of utilization and service data.

Enrollees

As with other managed care programs, DHS will receive monthly capitation premiums for every enrollee regardless of whether they access the system for services. The projected number of enrollees for 2002-03 was approximately 7,000, but this projection has increased to approximately 7,700. DHS is currently assessing the need to seek Board approval for an appropriation adjustment in response to the higher than expected enrollment.

By lowering the eligibility threshold of hours from 112 to 80 per month, DHS estimates that the number of enrollees would increase to 14,700, almost double the current 2002-03 projection.

Service Costs[2]

The data from DHS shows that the average DHS cost of an inpatient day and an outpatient visit are significantly higher than the average costs an inpatient day and outpatient visit in the Health Care Plan's financial analysis. Some of this variance may be due to the fact that the average DHS costs are based on total Departmental costs for all patient populations and not specifically on costs associated with the IHSS worker population. Because this variance is an important part of the analysis of cost-effectiveness, CAO staff is working with DHS staff to obtain additional service cost data for IHSS workers accessing services from DHS providers in order to complete this analysis.

Other Cost Factors

There are other cost factors which will affect the cost-effectiveness of the Health Care Plan, including Out-of-Plan and Pharmacy costs for the IHSS population. Out-of-Plan costs occur when a CHP Network enrollee accesses care outside of the CHP Provider Network. Although at this time the Out-of-Plan costs for the IHSS population appear to be consistent with the actuarial study, additional time is needed to determine the final impact on the program, based on CHP's experience with rising Out-of-Plan costs in the Medi-Cal Managed Care and Healthy Families Programs. Pharmacy costs are projected to be consistent with the actuarial study; however due to the anticipated health care needs of the IHSS workers, and rising pharmaceutical costs overall, these costs may be higher than anticipated as well.

Service Utilization

Service utilization is a key component for determining the costs of providing care to this population. The utilization data for this analysis was obtained from the DHS Information Report System (IR). The Department has concerns that the data obtained from the IR for total number of inpatient days and outpatient visits is understated. Earlier analysis suggested that there would be pent up demand for services from this population once benefits were offered under the Health Care Plan. However, this does not appear to be the case based on current data.

The utilization projected by DHS for IHSS workers for (based on the actuarial analysis) was compared to the IR utilization data for the period April through June 2002. Utilization for this three-month period based on the actuarial analysis was expected to generate approximately 720 inpatient days and 7,700 outpatient visits. The actual utilization data showed fewer than 100 inpatient days of service rendered, and fewer than 400 outpatient visits provided by DHS.

Because the IR utilization data provided by DHS is much lower than originally projected, the Health Care Plan appears to be cost-effective despite the higher average costs indicated above. However, DHS staff indicate that utilization may appear low due to inappropriate coding, for example, or other factors which they need to investigate. DHS will continue to provide standardized guidelines and staff training to DHS facilities staff. Additional analysis is needed to validate the IR data, and/or to determine to what extent inappropriate coding or other factors are affecting the utilization data. In addition, utilization could increase over time as IHSS workers become more familiar with the Health Care Plan benefits or as eligible IHSS workers continue to enroll in the Health Care Plan.

Impact of System Redesign

The potential impact of the Department's System Redesign and actions approved by the Board as of this date were considered during this review. The reduction of DHS health centers and the effect on the viability of this program with a reduction in the threshold from 112 hours per month to 80 hours were projected. Based on discussions with DHS, the impact appears to be minimal, as eligibles affected by the closures would be reassigned to another DHS site, which remains consistent with Knox-Keene Health Care requirements. However, it is unclear to what extent DHS would be able to retain these enrollees at DHS facilities and maintain the financial viability of the Health Care Plan for the County.

In its initial projections for whether the Health Care Plan would be financially viable, DHS projected that 75 percent of eligibles would be assigned to receive their care from a DHS facility within the CHP Provider Network. Given the current CHP Provider Network, approximately 95 percent of Health Care Plan enrollees are assigned to DHS facilities.

Further decisions have been delayed regarding the DHS System Redesign, including the possible conversion of two DHS facilities (Harbor/UCLA Medical Center and Olive View Medical Center) to Multi-Service Ambulatory Care Centers, should additional state and Federal assistance not become available. Therefore, it is difficult to determine the impact those changes would have on either the current Health Care Plan or the proposed expansion.

Conclusion

While the initial service cost and utilization data from DHS indicates that the Health Care Plan could remain financially viable with a change in the eligibility threshold to 80 hours per month, DHS and CAO staff have concerns regarding the reliability of the available data, as discussed in this report. Therefore, the final report on the cost-effectiveness of this change should be deferred until DHS and CAO staff can validate the service cost and utilization data to conclude their analysis of this issue.

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[1] Information provides by DHS from the Personal Assistance Services Council (PASC) IHSS Operational Steering Committee Meeting on October 2, 2002

[2] Information provided by DHS Program Audits/Reimbursement Division from the fiscal year 2001-02 Medicare Cost Reports.